

Lewy Body Dementia

What You May See

- Brief episodes of confusion and orientation to time or place
- Mild memory problems
- Symptoms can be temporary - vary from day to day or even throughout the day
- Well defined, vivid hallucinations (imaginary friend - usually small children, animals)
- Tremors or rigidity (especially if Haldol or other anti-psychotics given)

What Others May Report

- Person has rigid, false beliefs that can't be changed by convincing (someone is stealing from them, someone is in the house with them, spouse isn't real spouse but an alien in spouse's body, etc.)
- Person's symptoms go away and s/he "gets better" (e.g., sleep long time vs. up/fine).
- Imaginary people/animals are so real to the person that others work around the beliefs as if they are real (can't argue with them or convince them differently)
- Unexplained loss of consciousness, frequent falls
- Person's memory is usually OK

Criteria for Lewy Body Dementia*

- Dementia symptoms and 2 of 3 below:
 - Parkinsonism: slowness and stiffness
 - Recurrent detailed visual hallucinations, delusions (false beliefs)
 - Symptoms fluctuate markedly from day to day
 (Note: movement symptoms occur first, dementia/memory problems up to five years later)

Treatment*

- Responds well to Alzheimer's cholinesterase inhibitors
- If motor symptoms are disabling, may need to try cardopa/levidopa used in Parkinson's disease – may cause hallucinations, only use when safety is at risk and discontinue if hallucinations occur
- Avoid anti-psychotics because they will cause extreme rigidity (except for Seroquil)

Working with People who have Lewy Body Dementia

- Validate person's beliefs and hallucinations, work around them (e.g., escort "little visitors" out of the house if they are causing the person to be upset, etc.)
- Be aware that memory isn't effected or is only mildly effected
- Use strategies that help the person get a rhythm for movement (count, clap, hum)
- If swallowing problems, vary texture and temperature of food between bites to aid reflex (e.g., hot/cold, soft/chewy, etc.)
- Get adaptive aids to help person stay active and independent as long as possible (e.g., special eating utensils, walkers, etc.)

*Source: Susan Mickel M.D. from presentation at WI State Alzheimer's Association Conference 5/04

Frontal-Temporal Lobe Dementias

What you may see:

- Inappropriate behavior:
Compulsive drinking, swearing, hyper-sexual activities, shoplifting, etc. and repetitive actions; poor hygiene
- No insight into own behavior being inappropriate
- No apparent memory problems
- Language and speech problems - using wrong words, not able to be fluent
- Person may mimic your movements
- Effects younger people with age of onset 30's – 60's

What Others May Report:

- Person has probably been misdiagnosed as having a mental illness - not responding to help or treatment for it
- Person's personality has changed – suddenly become a different person
- Person is compulsively doing things and unable to recognize their own compulsion
- Person's memory is fine
- **Note:** people with this dementia need to be followed by dementia diagnostic experts

General Information on Frontal -Temporal Lobe Dementia

- Symptoms are gradual and progressive, onset not recognizable
- Deterioration of frontal and temporal lobes at different rates cause different patterns of symptoms in two categories:
 - Gradual progressive changes in behavior (frontal)
 - Gradual language dysfunction (temporal)

General Treatment of Frontal -Temporal Lobe Dementia

- Alzheimer's cholinesterase inhibitors don't usually help unless memory problems
- Treatments are targeted to specific symptoms (e.g., behavioral, movement, etc.)
- Complex treatment involving dementia symptoms and movement disorders – requires specialists, to balance treatments and not make other symptoms worse (e.g., anti-psychotics will exacerbate movement symptoms)

Four Subtypes of Frontal -Temporal Lobe Dementia*

1. **Frontotemporal Dementia (FTD)**
2. **Primary Progressive Aphasia (PPA)**
3. **Semantic Dementia (SD)**
4. **Cortical Basal Ganglionic Degeneration (CBGD)**

*Source: Malgorzata Franczak M.D. presentation at WI State Alzheimer's Association Conference 5/04

*Four Subtypes of Frontal -Temporal Lobe Dementia

1. Frontotemporal Dementia (FTD)

- Used to be called “Picks Disease” – Picks Bodies cannot be determined until an autopsy is done and are rare, not the only cause of FTD
- FTD is hereditary in 20%-40% of cases (Chromosome -17 linked)
- Parkinson’s symptoms occur in 10% of C-17 cases
- Early personality & behavior changes, memory is intact
- Emotional blunting with no insight into own deficits early in the disease
- Hyper-orality with overeating, overdrinking, hypersexuality (Kluver-Bucy Syndrome)
- Problems with calculation
- Mental rigidity
- Obsessive compulsive behavior
- Decline in personal hygiene, grooming
- Stereotyped behavior
- Primitive reflexes seen in babies (e.g., Babinsky Reflex on bottom of feet)
- Early urinary incontinence

2. Primary Progressive Aphasia (PPA)

- Language dysfunction is first symptom
- Early onset
- Incorrect use of grammar
- Looks like stroke symptoms but gets worse over time
- Starts with word finding difficulties, moves to non-fluent speech, then muteness
- Effects primarily the temporal lobe in left hemisphere
- Memory and visual-spatial skills are intact early in illness – first 2 years
- At end-stage it looks similar to end-stage Alzheimer’s disease

3. Semantic Dementia (SD)

- Very rare
- Effects both temporal lobes
- Compared to PPA the person is very fluent with speech
- Difficulty in naming and comprehension
- Unable to recognize common objects, functions
- Preserved memory and spatial skills

4. Cortical Basal Ganglionic Degeneration (CBGD)

- Effects right part of brain causing apraxia (impairing muscles that perform speech), rigidity of the left side of the body, and frequent falls
- “Alien Hand Syndrome”; Parkinson’s gait and tremor
- Can’t move eyes up and down
- People die more quickly than other dementia types

*Source: Malgorzata Franczak M.D. presentation at WI State Alzheimer’s Association Conference 5/04

Alzheimer's Disease

What You May See:

- Person may appear to be “normal”, memory problems may be hard to recognize
- Person may seem confused - looking for a car, person, place, etc., that only exists in his/her past
- Behavior may include:
 - Repeating same questions or phrases, wandering, driving erratically, decreased inhibitions, anxiety, agitation when confronted, startle sensitivity, answering questions with information from the past

What Others May Report:

- Person's changes were gradual over time, began with short-term memory problems
- Person thinks the past is the present (is younger)
- Rapid decline or behavior changes when ill (e.g., reversible causes like bladder infection)
- Person is like a child in her/his abilities, but can remember things from long ago
- Person can use his/her skills when prompted
- Note: behavior symptoms start more in mid-stage

Diagnosis of Alzheimer's Disease

- Specialized clinics/centers diagnose correctly 85-90% of the time
- Progressive cognitive decline with early memory loss and impairment in at least one other area of cognitive function
- Changes do not have other neurological signs or symptoms, psychiatric disease or systemic illness which the symptoms can be attributed to
- “Mixed Dementia” – other types along with Alzheimer's disease, usually accounts for the other 10-15% of cases where Alzheimer's is not diagnosed

Treatment (RX)

- **Cholinesterase inhibitors** – improve general alertness and slows clinical progression
 - Aricept (Donepezil)
 - Exelon (Galantamine)
 - Reminyl (Rivastigmine)
- **Namenda (Memantine)** – blocks “excitotoxicity” (too much glutamate in nerve cells) in the brain's hippocampus